HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your child's health care provider better understand your child's medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important.
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____ Other concerns: _____

CURRENT MEDICATIONS – Please list the medications your child currently takes. If he/she is not currently taking any medications, please check the "none" box to the right. ☐ None		
Name of Medication	**Dosage**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

MEDICATION/ALLERGY SENSITIVITY **List all medications your child is allergic to:** ☐ None
1.
2.
3.
4.

YOUR CHILD'S PROVIDERS – Please list the doctors your child sees in the community.
1.
2.

PHARMACIES – list the address and phone number for pharmacies, both local and mail away.
1.
2.

PAST MEDICAL HISTORY - Please check the box if your child has had or experienced these symptoms or medical issues. If none, indicate by checking the "none" box to the right. ☐None		
☐ ADD or ADHD	☐ Chicken Pox	☐ Heart Problems
☐ Allergies	☐ Congenital Anomalies	☐ Hospital Admission other than birth
☐ Anemia	☐ Constipation	☐ Muscle, Joint, or Bone Problems
☐ Asthma	☐ Depression	☐ Seizures/Epilepsy
☐ Bedwetting	☐ Developmental or Behavioral Disorders	☐ Serious Illness or Injuries
☐ Bladder or Kidney Problems	☐ Diabetes	☐ Skin Problems
☐ Blood Diseases	☐ Ear or Hearing Problems	☐ Thyroid Problems
☐ Cancer	☐ Eczema, Hives, or other skin conditions	☐ Vision or Eye Problems
☐ Other:		

SURGICAL PROCEDURES ☐ More than four		
Month/Year	Illness/Operation	Complication (Y/N)

To my understanding, this represents an accurate portrayal of my child's health history. I will inform Apple-A-Day Pediatrics as changes or updates occur.

_____

Patient Representative Signature Relationship Date